STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakepoint El Dorado, LLC	1313 S High Street El Dorado, KS 67042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 52 residents, with three residents sampled for abuse. Based on observation, record review, and interview, the facility failed to prevent the sexual abuse of cognitively impaired Resident (R) 3, who lacked the ability to consent. On 07/09/24 at approximately 03:30 PM to 04:00 PM, Certified Nurse Aide (CNA) N observed cognitively intact R2, who had a history of touching R3, with his hand inside R3's pant leg to her groin area. R3 had severe cognitive impairment and inability to consent, placing her in immediate jeopardy, based on a reasonable person concept, and at risk for trauma and a negative psychosocial impact. Finding included: - The Admission Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. R2 had no behaviors or limits in his range of motion and used a wheelchair for mobility which he could move independently. The Care Plan initiated on 04/30/24 for R2 revealed he required a wheelchair for locomotion propelled by staff and may propel self at times short distances. The Care Plan lacked any behavior issues or interventions related to touching other residents without their consent. The Quarterly MDS dated [DATE], assessed R3 with a BIMS score of three, indicating severe cognitive impairment, used a wheelchair and a walker for mobility, and required staff supervision for wheelchair mobility. The Care Plan included an intervention dated 02/28/24 for R3, which revealed she could propel herself in her wheelchair but frequently got lost and required redirection. A revision on 07/14/24, regarding R3's impaired cognitive function/dementia/impaired thought processes, noted the resident had difficulty recalling recent events and a BIMS score of three. The staff were to provide verbal cues/reminders when R3 had trouble remembering where she was, where she was going, mealtimes, etc. The care plan lacked any interventions related to her ability to consent to touching by R2. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Grievance/Complaint Report dated 07/01/24, revealed an unidentified nursing staff member reported a concern to Administrative Nurse D and Social Services Staff X regarding R2. The unidentified staff member saw R2 holding an unidentified resident's hand and touched her thigh. When Administrative Nurse D and Social Service Staff X visited with R2 about this he acted like he did not know what they were talking about. They explained to R2 there cannot be physical contact with other residents and R2 stated Ok. The form revealed the staff did not update the resident's care plan. The Incident/Statement Report dated 07/09/24 by CNA N revealed she witnessed R2 in his doorway and R3 directly at his doorway. R2 had his right hand inside R3's left pant leg all the way to her groin. CNA N documented they stated Hey [R3] and then R2 pulled his hand out. The Progress Note for R3 dated 07/10/24 at 05:04 PM, revealed a social service note indicated a call to family about another resident who may have had possible contact with R3. The note indicated the facility made a police report, contacted the state, and was conducting an investigation. The family stated they knew R3 could not remember things anymore and would like called if the facility had any more information. The Progress Note for R3, dated 07/12/24 at 05:13 PM, revealed on 07/11/24 staff called the resident's family to talk about the incident and went over their current knowledge of the incident. The note included the staff would let the family member know more when the facility knew more about the incident. The note revealed the staff later contacted the family on 07/11/24 to let them know the other person [R2] no longer resided at the facility. The Progress Notes for R3, from 06/25/24 to 07/22/24, lacked documentation of the specific incident of contact by another resident on 07/09/24, or any other instances prior to that date. The Progress Notes for R2 from 04/25/24 through 07/11/24, lacked any behavior issues or contact with any other residents and revealed on 07/11/24 at 02:24 PM R2 stated he would like to walk out of the facility and R2 discharged from the facility on this date. The facility Witness Statement dated 07/15/24, by Administrative Staff A revealed R3 had no memory of the incident and R2 told police he was just having a little fun and did not realize he was doing anything wrong. R2 told the police he did put his hand in R3's pant leg and touched her thigh. The facility Witness Statement dated 07/15/24, by Administrative Staff B revealed she observed on one occasion (the statement lacked a date) she walked up to R2 and R3, who were sitting at a table in the round area, sitting very close to each other and R2 had his hand resting on R3's arm. When Administrative Staff B walked over to them, R2 removed his hand and immediately turned and propelled his wheelchair down the hall towards the dining room. The facility Witness Statement dated 07/15/24, by CNA M revealed she observed (the statement lacked date) R2 touching R3's knee, R3 rolled backwards and said she needed the restroom. CNA M removed R3 from the situation and took her to the bathroom. Once finished and on the way to the dining room, R2 was sitting in the common area and tried to reach out to R3 and R3 moved away from R2 in the chair, so CNA M moved R3 farther away where R2 could not reach R3. CNA M included she observed a few times (the statement lacked dates) when staff would take R3 down the hallway in her wheelchair she would lean her body to the opposite side of the chair that R2 was on, trying to stay out of his reach. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 07/22/24 at 11:25 AM, revealed the room R2 resided in was on the opposite side of the hallway in which R3 resided on. Between the hall R2 and R3 resided on was the round area with the nurse's station located between the round area and R2's room. An observation on 07/22/24 at 12:57 PM, revealed R3 seated in her wheelchair in the round area next to a different hallway from the one she resided on. On 07/22/24 at 11:30 AM, CNA M stated she was assisting R3 to the dining room when R2 went to reach for R3, and R3 leaned the opposite way in the wheelchair. CNA M stated she moved R3 over in the hallway so R2 could not reach her as it appeared to make R3 uncomfortable. CNA M could not recall when that occurred. CNA M stated it was shifts after that she saw R2's hand on R3's knee in the circle area and would see R3 lean her body away from R2 if they were meeting in the hallway. CNA M stated she could not recall the date she observed R2 with his hand on R3's knee, but she did let a nurse know (could not recall who) and thought it was close to 07/04/24. CNA M stated R3 did not seem upset when she assisted her to the bathroom after R2 had his hand on her knee, however, R3 made the comment she was better since she was in her own room and space. On 07/22/24 at 12:27 PM, Administrative Staff B stated within the week of the incident on 07/09/24 between R2 and R3, she observed R3 seated at the table in the round area with her arm resting on the arm of the wheelchair and R2 sat next to her with his hand on her forearm and appeared to be talking to R3. Administrative Staff B stated the situation did not look weird until R2 looked up and saw Administrative Staff B and R2 rolled his wheelchair away. Administrative Staff B stated it was not uncommon to see R2 and R3 sit together at the table and talk, and she did not report her observation of R2's hand on R3 and rolling away when R2 saw her to any other staff. On 07/22/24 at 12:37 PM, CNA N stated on 07/09/24 around 03:30 PM to 04:00 PM she observed R2's right hand up R3's left pant leg all the way to her groin. CNA N stated when she observed that she stated to R3 'let's go find your sock' and removed her away from R2. As soon as she did that, R2 slammed his room door shut and did not come out the rest of the shift. CNA N stated she had another CNA take over for R3 and CNA N reported her observation. On 07/22/24 at 03:02 PM, Administrative Staff A stated CNA N reported the incident on 07/09/24 to her and R3 had no recollection of the event and R2 said he was having a little fun and did not know he was doing anything wrong, which is what he reported to the police officer. Administrative Staff A stated she was aware of one other time R2 had touched R3 on the shoulder and patted her leg and Administrative Nurse D investigated and talked to R2 about not doing that. On 07/22/24 at 03:36 PM Administrative Nurse D stated she had not received any other reports of R2 touching R3 besides when CNA M reported on 07/01/24 R2 touched R3's knee, and the occurrence on 07/09/24. Administrative Nurse D stated it would be a concern if staff observed R2 touching R3's arm, then moving it away when staff approached, and she was not aware of that occurring. Administrative Nurse D stated R2's behaviors should have been documented in his chart and there was an incident report for R3, but not R2. The facility policy Abuse, Neglect, and Exploitation dated May 2024 revealed the policy was to ensure residents of the community would be free of physical, emotional, and sexual abuse. Abuse included willful infliction of injury, unreasonable confinement, intimidation, verbal abuse, sexual abuse with willful meaning the individual acted deliberately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to prevent the sexual abuse of R3, who had severe cognitive impairment and the inability to consent, when R2 put his hand up R3's pant leg to her groin area, placing R3 at risk for immediate jeopardy and at risk for trauma and a negative psychosocial impact. On 07/22/24 at 06:15 PM Administrative Staff A was informed of the immediate jeopardy and provided the Immediate Jeopardy template for failure to prevent the sexual abuse of R3 on 07/09/24 at approximately 03:30 PM to 04:00 PM when R2 had his hand up R3's pant leg up to her groin. The facility provided a plan for removal of the immediacy on 07/23/24 at 05:32 PM, accepted on 07/23/24 at 08:07 PM, which included R2 no longer resided in the facility and all staff would be re-educated on and provided a copy of the Abuse, Neglect, and Exploitation policy by 07/26/24. The surveyor verified the implementation of the above corrective actions onsite on 07/24/24 at 05:10 PM and the deficient practice remained at a G scope and severity, based on reasonable person concept.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 52 residents, with three residents sampled for abuse. Based on observation, record review, and interview, the facility failed to protect cognitively impaired Resident (R) 3, who lacked the ability to consent, from sexual abuse. On 07/09/24 at approximately 03:30 PM to 04:00 PM, Certified Nurse Aide (CNA) N observed cognitively intact R2, who had a history of touching R3, with his hand inside R3's pant leg to her groin area. R3 had severe cognitive impairment and inability to consent, placing her in immediate jeopardy, based on a reasonable person concept, and at risk for trauma and a negative psychosocial impact. Finding included: - The Admission Minimum Data Set (MDS) dated [DATE], assessed R2 with a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. R2 had no behaviors or limits in his range of motion and used a wheelchair for mobility which he could move independently. The Care Plan initiated on 04/30/24 for R2 revealed he required a wheelchair for locomotion propelled by staff and may propel self at times short distances. The Care Plan lacked any behavior issues or interventions related to touching other residents without their consent. The Quarterly MDS dated [DATE], assessed R3 with a BIMS score of three, indicating severe cognitive impairment, used a wheelchair and a walker for mobility, and required staff supervision for wheelchair mobility. The Care Plan included an intervention dated 02/28/24 for R3, which revealed she could propel herself in her wheelchair but frequently got lost and required redirection. A revision on 07/14/24, regarding R3's impaired cognitive function/dementia/impaired thought processes, noted the resident had difficulty recalling recent events and a BIMS score of three. The staff were to provide verbal cues/reminders when R3 had trouble remembering where she was, where she was going, mealtimes, etc. The care plan lacked any interventions related to her ability to consent to touching by R2. The Grievance/Complaint Report dated 07/01/24, revealed an unidentified nursing staff member reported a concern to Administrative Nurse D and Social Services Staff X regarding R2. The unidentified staff member saw R2 holding an unidentified resident's hand and touched her thigh. When Administrative Nurse D and Social Service Staff X visited with R2 about this he acted like he did not know what they were talking about. They explained to R2 there cannot be physical contact with other residents and R2 stated Ok. The form revealed the staff did not update the resident's care plan. The Incident/Statement Report dated 07/09/24 by CNA N revealed she witnessed R2 in his doorway and R3 directly at his doorway. R2 had his right hand inside R3's left pant leg all the way to her groin. CNA N documented they stated Hey [R3] and then R2 pulled his hand out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Note for R3 dated 07/10/24 at 05:04 PM, revealed a social service note indicated a call to family about another resident who may have had possible contact with R3. The note indicated the facility made a police report, contacted the state, and was conducting an investigation. The family stated they knew R3 could not remember things anymore and would like called if the facility had any more information. The Progress Note for R3, dated 07/12/24 at 05:13 PM, revealed on 07/11/24 staff called the resident's family to talk about the incident and went over their current knowledge of the incident. The note included the staff would let the family member know more when the facility knew more about the incident. The note revealed the staff later contacted the family on 07/11/24 to let them know the other person [R2] no longer resided at the facility. The Progress Notes for R3, from 06/25/24 to 07/22/24, lacked documentation of the specific incident of contact by another resident on 07/09/24, or any other instances prior to that date. The Progress Notes for R2 from 04/25/24 through 07/11/24, lacked any behavior issues or contact with any other residents and revealed on 07/11/24 at 02:24 PM R2 stated he would like to walk out of the facility and R2 discharged from the facility on this date. The facility Witness Statement dated 07/15/24, by Administrative Staff A revealed R3 had no memory of the incident and R2 told police he was just having a little fun and did not realize he was doing anything wrong. R2 told the police he did put his hand in R3's pant leg and touched her thigh. The facility Witness Statement dated 07/15/24, by Administrative Staff B revealed she observed on one occasion (the statement lacked a date) she walked up to R2 and R3, who were sitting at a table in the round area, sitting very close to each other and R2 had his hand resting on R3's arm. When Administrative Staff B walked over to them, R2 removed his hand and immediately turned and propelled his wheelchair down the hall towards the dining room. The facility Witness Statement dated 07/15/24, by CNA M revealed she observed (the statement lacked date) R2 touching R3's knee, R3 rolled backwards and said she needed the restroom. CNA M removed R3 from the situation and took her to the bathroom. Once finished and on the way to the dining room, R2 was sitting in the common area and tried to reach out to R3 and R3 moved away from R2 in the chair, so CNA M moved R3 farther away where R2 could not reach R3. CNA M included she observed a few times (the statement lacked dates) when staff would take R3 down the hallway in her wheelchair she would lean her body to the opposite side of the chair that R2 was on, trying to stay out of his reach. An observation on 07/22/24 at 11:25 AM, revealed the room R2 resided in was on the opposite side of the hallway in which R3 resided on. Between the hall R2 and R3 resided on was the round area with the nurse's station located between the round area and R2's room. An observation on 07/22/24 at 12:57 PM, revealed R3 seated in her wheelchair in the round area next to a different hallway from the one she resided on. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/22/24 at 11:30 AM, CNA M stated she was assisting R3 to the dining room when R2 went to reach for R3, and R3 leaned the opposite way in the wheelchair. CNA M stated she moved R3 over in the hallway so R2 could not reach her as it appeared to make R3 uncomfortable. CNA M could not recall when that occurred. CNA M stated it was shifts after that she saw R2's hand on R3's knee in the circle area and would see R3 lean her body away from R2 if they were meeting in the hallway. CNA M stated she could not recall the date she observed R2 with his hand on R3's knee, but she did let a nurse know (could not recall who) and thought it was close to 07/04/24. CNA M stated R3 did not seem upset when she assisted her to the bathroom after R2 had his hand on her knee, however, R3 made the comment she was better since she was in her own room and space. On 07/22/24 at 12:27 PM, Administrative Staff B stated within the week of the incident on 07/09/24 between R2 and R3, she observed R3 seated at the table in the round area with her arm resting on the arm of the wheelchair and R2 sat next to her with his hand on her forearm and appeared to be talking to R3. Administrative Staff B stated the situation did not look weird until R2 looked up and saw Administrative Staff B and R2 rolled his wheelchair away. Administrative Staff B stated it was not uncommon to see R2 and R3 sit together at the table and talk, and she did not report her observation of R2's hand on R3 and rolling away when R2 saw her to any other staff. On 07/22/24 at 12:37 PM, CNA N stated on 07/09/24 around 03:30 PM to 04:00 PM she observed R2's right hand up R3's left pant leg all the way to her groin. CNA N stated when she observed that she stated to R3 'let's go find your sock' and removed her away from R2. As soon as she did that, R2 slammed his room door shut and did not come out the rest of the shift. CNA N stated she had another CNA take over for R3 and CNA N reported her observation. On 07/22/24 at 03:02 PM, Administrative Staff A stated CNA N reported the incident on 07/09/24 to her and R3 had no recollection of the event and R2 said he was having a little fun and did not know he was doing anything wrong, which is what he reported to the police officer. Administrative Staff A stated she was aware of one other time R2 had touched R3 on the shoulder and patted her leg and Administrative Nurse D investigated and talked to R2 about not doing that. On 07/22/24 at 03:36 PM Administrative Nurse D stated she had not received any other reports of R2 touching R3 besides when CNA M reported on 07/01/24 R2 touched R3's knee, and the occurrence on 07/09/24. Administrative Nurse D stated it would be a concern if staff observed R2 touching R3's arm, then moving it away when staff approached, and she was not aware of that occurring. Administrative Nurse D stated R2's behaviors should have been documented in his chart and there was an incident report for R3, but not R2. The facility policy Abuse, Neglect, and Exploitation dated May 2024 revealed the policy was to ensure residents of the community would be free of physical, emotional, and sexual abuse. Abuse included willful infliction of injury, unreasonable confinement, intimidation, verbal abuse, sexual abuse with willful meaning the individual acted deliberately. The facility failed to protect R3, who had severe cognitive impairment and the inability to consent, from sexual abuse, when R2 put his hand up R3's pant leg to her groin area, placing R3 at risk for immediate jeopardy and at risk for trauma and a negative psychosocial impact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/22/24 at 06:15 PM Administrative Staff A was informed of the immediate jeopardy and provided the Immediate Jeopardy template for failure to protect cognitively impaired R3 from sexual abuse on 07/09/24 at approximately 03:30 PM to 04:00 PM when R2 had his hand up R3's pant leg up to her groin, and R3 lacked the capacity to consent. The facility provided a plan for removal of the immediacy on 07/23/24 at 05:32 PM, accepted on 07/23/24 at 08:07 PM, which included R2 no longer resided in the facility and all staff would be re-educated on and provided a copy of the Abuse, Neglect, and Exploitation policy by 07/26/24. The surveyor verified the implementation of the above corrective actions onsite on 07/24/24 at 05:10 PM and the deficient practice remained at a G scope and severity, based on reasonable person concept.